EXECUTIVE SUMMARY

The story of our state's health is not just the presence or absence of disease or injury. Our health includes how different conditions allow us to live healthy lives (where we live, how we get to places, the air we breathe, etc.).

This assessment weaves together data from different areas across the state so we can understand what impacts our health. It aims to do the following:

- Explain how conditions like social factors, systems, and structures impact the health of people in Minnesota.
- Elevate data on systems, which show how policies and programs create and sustain conditions for health.
- Explicitly call out where and how structural racism is impacting health in Minnesota.
- Highlight assets, strengths, and resources of communities as they relate to health.
- Show where organizations and groups can get involved to address inequities, thus addressing health inequities and improving health.

A note about COVID-19: This assessment includes some data about the COVID-19 pandemic, but COVID-19 is not the main focus. The challenge for this assessment is not only to document the direct impact of COVID-19 on Minnesota and those living in Minnesota, but to recognize the influence of COVID-19 on many issues highlighted in the assessment.

Data availability: Limited statewide data is available for some populations, such as people with disabilities, the LGBTQ+ community (lesbian, gay, bisexual, transgender, and queer/questioning), and specific ethnic and cultural groups. This lack of representation makes it challenging to accurately report health and health inequities experienced by these populations. More work is needed and is underway to address these data gaps.

The statewide health assessment gives us a picture of our state's health.

It tells the story, at this point in time, of the different factors impacting our health in Minnesota. These factors include our environment, education, housing, transportation, social circles, and more.

The statewide health assessment is completed roughly every five years. It looks at data across time and by different groupings to better understand how a topic might influence our health. The assessment is not a complete collection of all data available. Rather, it collects some information across various topics that should be seen as starting points for where to dig in deeper.

The assessment looks at the people in Minnesota and how opportunity, nature, and belonging impacts our health.

The assessment uses the same four sections from the 2017 assessment—people, opportunity, nature and belonging. These sections look across different conditions and how they impact our health.

PEOPLE

OPPORTUNITY

NATURE

BELONGING

People

Who we are, where we've come from, and our real and perceived differences play a role in shaping our health.

Between 2018 and 2053:

- Overall, Minnesota is projected to gain nearly 900,000 residents.
- The number of Minnesotans ages 85 and older is expected to more than double, from 120,000 to more 270,000.
- The seven-county metro region is projected to gain about 924,000 residents and Greater Minnesota will shrink by about 27,000 residents.[1]

Populations of color and American Indians are projected to grow by more than **1 million residents** — exceeding **one-third** of the total population. Virtually all the state's net population growth in the coming decades will be from populations of color.

NEW FOR THIS ASSESSMENT:
Demographic information is included for people experiencing homelessness and people experiencing incarceration in our state. These populations are often invisible, though they face health inequities in accessing resources and support for living healthy lives.

Opportunity

Inequitable social and economic opportunities impact our health — in education, employment, income, housing, transportation, and more. Data exposes the persistent inequities that continue to affect some groups more than others, and cause generations of poor health.

In 2021:

- 20.2% of people in Minnesota reported not seeking health care (dental, mental, prescriptions, routine medical, or specialist care) due to cost. Some groups of people were more likely not to seek care, including people who were uninsured; had individual or public insurance plans; American Indian, Hispanic/Latine between the ages of 26 and 64; had a chronic condition; or had income at or below 200% of the federal poverty guidelines.[3]

The combined cost of transportation and housing for the typical family in Minnesota (two adults, one child, 1.5 workers) accounted for **21.8%** of median household income.[2]

NEW FOR THIS ASSESSMENT:
A policy profile on paid family and medical leave describes why it matters for health, what inequities exist, and what policies are in place (at local, state, national and institutional levels).

Nature

Our health is shaped by our connection to and interactions with the natural environment. This includes environmental benefits (such as green spaces, tree canopy, clean air, and clean water) and exposure to environmental dangers (such as air pollution, waste, and contaminated water).

- In the Twin Cities, about half of the seven-county metro area is in or within one mile of an environmental justice area: areas that are either within a Federally recognized tribal area or have a high proportion of residents who are not white, low-income, or have limited English proficiency[a].[4] This covers about 1.6 million people, or just over half of Twin Cities residents.[5] In Greater Minnesota, approximately 55% of census tracts are in environmental justice areas, including 1.3 million people (51% of all Greater Minnesota residents).[6]

NEW FOR THIS ASSESSMENT:
A policy profile on tree canopy cover, or how much of an area is shaded by trees, describes why it matters for health, what inequities exist, and what policies are in place (at local, state, and national levels).

Minnesota warmed by **3.0 degrees** Fahrenheit between 1895 and 2020, while annual precipitation increased by an average of 3.4 inches.[7]

Belonging

Being included in our communities, and our connections with each other, can improve or weaken our lifelong health.

- According to the 2023 senior report, Minnesota ranks number four as one of the healthiest states in the nation for older adults. However, Minnesota's normalized value (a method that crunches data to a common scale) for risk of social isolation for people aged 65 is 32, with one being the best and 100 the worst or more at risk for social isolation.[9]
- In 2022, 61% of eligible people in Minnesota voted, the highest rate of voter turnout in the nation.[10]

In 2021, Minnesotans reported an average of **4.3** mentally unhealthy days in the past 30 days, more than twice as many per month as they reported in 2013.[8]

NEW FOR THIS ASSESSMENT:
A policy profile on universal broadband internet access describes why broadband matters for health, existing inequities, and policies in place at corporate, local, state, and national levels.

a In 2023, the Minnesota Legislature created and defined "environmental justice areas" in Minnesota law. These areas were created to address health problems that disproportionately hurt Black, Indigenous, and People of Color in Minnesota, like those resulting from air pollution levels above state guidelines. The full list of criteria for these areas is available in the assessment.

How was this assessment put together?

The assessment was developed under the guidance of the Healthy Minnesota Partnership and Minnesota Department of Health. The Healthy Minnesota Partnership brings together community partners and the Minnesota Department of Health (MDH) to improve the health and quality of life for people, families, and communities in Minnesota. It is comprised of leaders from different sectors and areas of Minnesota, brought together by the commissioner of health. The Partnership is charged with developing a statewide health improvement framework, which is an action plan to help all people in Minnesota live a healthy life. The phrase "Partnership staff" in this assessment refers to MDH staff who are members of the Healthy Minnesota Partnership. These staff are identified in Appendix A.

The process of developing the statewide health assessment is as important as the report itself. It is a collaborative process involving multiple partners, relying on feedback loops and input from these groups.

- **Data collection:** The assessment relies on data from many organizations and sources across the state and nation. This data already exists. This data was not collected for the sole purpose of the assessment. For more details about data collection, please see Appendix A.
- **Community engagement:** Healthy Minnesota Partnership staff conducted multiple community engagement activities to include input while developing the assessment. These activities included a community engagement inventory, group conversations, a survey on state strengths, and public comment. Staff planned activities with the understanding that communities have engagement fatigue and do not want to be defined solely by deficits. Demographics were only collected for the state strengths survey and for people who filled out the written form for public comment. These demographics demonstrate that these samples are not a representative sample of the state. For more details about community engagement, please see Appendices A, B, C, D, and E. engagement fatigue and do not want to be defined solely by deficits. For more details about community engagement, please see Appendices A, B, C, D, and E.

What's next?

This assessment provides information that will be used to develop a statewide health improvement framework. The framework lays out health priorities and strategies for addressing them. The Healthy Minnesota Partnership will convene in 2024 to plan and develop this framework. MDH and the Minnesota Healthy Partnership encourage community organizations, government agencies, and other partners to join in on this process.

FORWARD: LETTER FROM COMMISSIONER CUNNINGHAM

We are excited to share Minnesota's Statewide Health Assessment. The Healthy Minnesota Partnership and MDH Partnership staff have produced a robust report, full of data and insights about the health status of people in Minnesota. The health issues that we highlight reflect feedback from the Partnership, review of select community health needs assessments, survey data, and public comment. A "snapshot" of health in Minnesota at this moment in time, the assessment is intended to be a resource for anyone who wants to improve health in our state and the foundational document upon which we will build our State Health Improvement Plan.

Not surprising, much of the data is consistent with what we have seen before. Our state compares quite well compared to other states on health metrics, in part due to overall high educational attainment, low unemployment, and low rates of uninsurance. However, the data again show people identifying as Black and American Indian in Minnesota have worse health outcomes across most metrics, reflecting the persistent challenges of eliminating health inequities in our state. The data only partially reveal the impact of the COVID-19 pandemic, which we know has left a wake of increased health needs. Those increased needs stem from foregone care during the pandemic; declines in mental health because of stress, isolation, and the loss of loved ones; worse access to care due to the reduction of the health care workforce, hospital and clinic closures, and the termination of services; the pandemic's socio-economic impacts, which led to unemployment, homelessness, and worsened food insecurity for many; and long Covid. And this is on top of other ongoing social problems – such as mass incarceration, gun violence, and poverty – which create their own health problems, not just for individuals but also for families and for communities.

The Healthy Minnesota Partnership again has highlighted racism as one of the fundamental drivers of poor health outcomes. As we move forward with our State Health Improvement Plan, if the goal is to dismantle racism, we will need to be quite specific about the pathways through which racism impacts health. Regrettably, it is still the case that we have a lot of race data but very little racism data. That's part of the history of health assessment with which we must reckon — that we collect information about respondents' social identities rather than data about the practices and policies contributing to substantial racial differences in access to resources, opportunity, information, and power. We must clarify the who, what, when, where, and how of racism, recognizing that racism can mutate like a virus.

It shows up differently for people and communities of color across time, geography, gender, ethnicity, age cohort, religious affiliation, citizenship, immigration status, sexual orientation, disability status, and duration and history in this place we now call Minnesota. Hence, the calls to work more closely with those who are most negatively impacted by racial disparities in health so that we can understand with greater precision the various ways in which racism works, fill the gaps in our traditional data collection methods, and more confidently identify priorities for health programs and policy change.

We must also steadfastly reject some core premises that undergird racism. To partner more powerfully to improve health and safety, we must reject division, "us vs. them," and cast off our fears of scarcity. As we develop targeted solutions for local communities, we must also come together across differences and geography to hammer away at the shared barriers to optimal health. We must remember that we can do both. We can attend to different lived experiences and double-down on those community risk factors that contribute to adverse health outcomes in both predominantly White communities in rural Minnesota and in predominantly Black and Brown neighborhoods in the Metro. Together, we can support asset-based approaches that increase social connection and belonging, empower people and communities, increase self-determination, improve civic engagement, and honor, rather than stigmatize, culture – all methods proven to protect health.

Together, we can build a future state in which public health departments, hospitals and clinics, especially safety-net providers, community-based organizations, and families do not have to carry the heavy loads of a broken system.

As we gear up for the road ahead, we can find hope in our state's strengths. We know from the engagement that went into this assessment that Minnesota continues to excel in several ways. People in Minnesota benefit from the many programs that support families; the numerous parks, playgrounds, and other outdoor spaces that are accessible, well-maintained, and protected; an active, diverse, and community-oriented non-profit sector; and ample opportunities to volunteer or get involved in one's community. These are state characteristics we can be proud of and build upon as we promote health and well-being.

The assessment is a resource for the many people in Minnesota who are working together within and across communities and in multiple sectors to create a state where every person can truly thrive, no matter who they are, where they live, the body that they are in, the work they do, how much money they make or wealth they have, or who they love. I am so grateful for of all who have participated in the Healthy Minnesota Partnership thus far and am excited about plans to expand and diversify the Partnership so that more community voices are at the table. A big "thank you" to all the Partnership staff who produced this excellent report and to all who believe that we can make a difference.